

Commission to Study Difficult-to-place Patients
November 20, 2015
Meeting Summary

Convened 10:00 p.m., Room 216, Cross State Office Building, Augusta

Present:
Sen. Roger Katz
Sen. Anne Haskell
Rep. Drew Gattine
Rep. Richard Malaby
Rep. Peter Stuckey
Jeff Austin
Melvin Clarrage
Richard Erb
Brenda Gallant
Ricker Hamilton
Simonne Maline
Kim Moody

Absent:
None

Staff:
Natalie Haynes
Dan Tartakoff

Introductions

Commission Chair Roger Katz called the meeting to order and the members introduced themselves. Commission members reviewed the agenda for the day and Commission staff described for members the various handouts and documents on their desks.

Information requests made of Maine Health Care Association

The Commission first heard from Mr. Erb on behalf of the Maine Health Care Association (MHCA) regarding requests for information made at the last meeting. The first question asked was for information on the rates that the 3 geropsych facilities are receiving from the State. Mr. Erb stated that the relevant rates were \$328 to \$344 per day (a figure which includes the cost for a private room), except for the Mount Saint Joseph's facility in Waterville, which has 16 PNMI geropsych beds and comes in at \$227 per day. He noted that these rates are respectively higher than the average nursing facility rate (around \$200 per day) and the average PNMI rate (around \$100 per day). Sen. Katz questioned whether, given that there appears to be a demand for these types of beds and the rate appears to be adequate, there have been any efforts made to add more beds. Mr. Erb responded that perhaps because these facilities would be subject to the Certificate of Need (CON) statutory requirements and budget neutrality caps, no initiative to add more geropsych beds has been put forward in recent years.

The second question asked of MHCA was what suggestions they had for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these complex patient populations. Mr. Erb noted that the geropsych PNMI concept employed by Mount Saint Joseph appears to be serving those patients' needs well, and that perhaps this concept could be expanded to include additional beds in the State. He also stated that MHCA supports expansion of

geropsych beds in the nursing facility setting. He did caution, however, that the CON statutory requirements and budget neutrality caps must be addressed to expand capacity in these areas.

The third question asked of MHCA regarded their position on the feasibility of implementing a presumptive eligibility standard/option, where a provider would have the ability to presume Medicaid eligibility for a patient with later DHHS determination. Although MHCA would certainly support the implementation of such a concept, Mr. Erb expressed concern over the feasibility of implementing this process, especially in terms of the potential issues created for a provider who presumes eligibility and accepts a patient who is later denied. Mr. Austin noted that hospitals are currently able to presume eligibility in some cases and start receiving payments. He suggested that this proposal has merit and should be discussed further. Mr. Hamilton noted that often a MaineCare denial involves financial exploitation of the applicant by family members, and that DHHS is taking steps to address these issues, including the creation of a two-person financial abuse specialist team. One proposal DHHS is looking into is requiring a contractual agreement between DHHS and the applicant's family to create a legally binding obligation on the part of the family to pay for care if denied. Rep. Gattine asked Mr. Hamilton to provide some statistics to the Commission regarding how many of these types of financial exploitation cases the Department typically deals with.

The final question for MHCA concerned the proposal to implement a basic reporting requirement for facilities refusing patient placement. Although MHCA recognized that the information collected through such a process may be useful, they remain opposed to a formalized reporting requirement, even if it's just a simple, one-page form. One of the reasons for this opposition relates to how many of these cases are too complex to address in a simple form and concern over the reporting turning into a debate over the denial of placement. Ms. Moody stated that collecting this information would be critical to fully understanding the issues involved with a denial of placement. Ms. Gallant agreed, suggesting that perhaps just requiring reporting on a refusal to re-admit would lessen the burden on the facilities and still provide useful data. Mr. Erb responded that readmission refusals are rare and already require additional reporting to DHHS.

Information requests made of Maine Hospital Association

The Commission next heard from Mr. Austin on behalf of the Maine Hospital Association (MHA). The first question for MHA requested specific information on the proposed "days awaiting placement" rate for hospital patients. Mr. Austin responded that this rate should essentially mirror the existing days awaiting placement rate paid to critical access hospitals under the MaineCare manual. This rate is the statewide average nursing facility rate, which is just under \$200 per day. He suggested that this proposal be implemented for the first year on a sort of pilot program basis, and that instead of including a per patient cap, the reimbursement be funded with an appropriation of \$500,000 or \$1 million and that, once that amount is exhausted, no more reimbursement will be paid for the rest of the year.

The second question for MHA concerned whether other states have taken a similar approach with respect to this issue. Mr. Austin responded that he canvassed the other New England states and determined that no other state has a days awaiting placement rate for hospitals under these same circumstances. He cautioned, however, that it is difficult to compare medical payment systems in different states and each state has developed a unique and complex model that doesn't necessarily lend itself to simple comparison.

Information requests made of Maine DHHS

The Commission next heard from Mr. Hamilton on behalf of Maine DHHS, which had provided a written handout addressing the questions asked of it. The first question concerned the eligibility and placement process for geropsych patients in the case of an open bed. Mr. Hamilton acknowledged that the process can unfortunately take some time, but described the many steps involved in the process and the complexities involved. He noted, however, that DHHS is currently reviewing the process to identify streamlining opportunities to speed up placements.

The second question for DHHS concerned the suggestion made during a prior public comment that the State is only financially responsible for Maine residents receiving treatment out-of-state for the first two years of treatment out-of-state. Mr. Hamilton responded that, for MaineCare patients, if an individual is temporarily or involuntarily absent from the State, but intends to return in the future, then MaineCare eligibility will continue indefinitely.

The third question for DHHS concerned the possibility of expanding the Homeward Bound program and securing additional grants. Mr. Hamilton outlined the federal grant process for this program, noting that at this time, federal grant monies have been requested for calendar year 2016 through September 30, 2020 and that no additional funds can be requested. He noted, however, that the number of individuals available to transition appears to be decreasing, with 13 transitions to date and up to 7 more projected by the end of the year – a number lower than the current goal of 26 placements per year. In discussions surrounding this question, Ms. Gallant noted that a significant barrier to community placement concerns staffing, which is likely hampered by the flat and low rate paid for home care services. She suggested that consideration of an enhanced rate for home care services based on the needs of the individual would go a long way towards improving community placement rates.

The final question for DHHS concerned the potential expansion of the negotiated rate process for complex patient populations. Mr. Hamilton expressed the Department's position that the standardized rate process is preferred in most cases, but that for patients that have complex needs, DHHS may negotiate rates with providers, such as in the case of geropsych rates.

Information requests made of Disability Rights Maine

The Commission lastly heard from Ms. Moody on behalf of Disability Rights Maine (DRM), regarding proposals to address compliance and enforcement issues, on which she provided a written handout with attachments. Ms. Moody described a number of proposals to address DRM's concerns, including amending 22 MRSA §7948 regarding unlawful discharges and clarifying DHHS' licensing's ability to enforce law/rules regarding unlawful patient discharges.

Public comment

John Gregoire testified on behalf of the Hope-JG Foundation, which has been working towards building a world class ALS/MS residence in Maine. Mr. Gregoire described the mission of his foundation and its plans for the future. He reiterated that the construction of the facility would be privately funded, but asked the Commission to ensure that the appropriate regulatory system is in place to allow such a facility to be constructed and operated. After describing the green house facility concept, Commission members requested from Mr. Gregoire a list of other states that have addressed green house facilities in their statutes and regulations.

Commission discussion on proposals and recommendations

The Commission next began its discussion on the various identified issues and proposals for recommendations to be included in the final report. At Mr. Austin’s suggestion, the Commission agreed to attempt to divide proposals into three categories – those requiring immediate and specific action this upcoming session, those requiring further future study by stakeholders, those that are more appropriately addressed by DHHS and other relevant parties and those that lack merit and should not be included in the report. For the purposes of determining which proposals to include in the draft report, members agreed to take non-binding straw votes on the proposals.

During these discussions, Mr. Austin had to leave and, with the Chair’s permission, gave his seat and voting authority to Lisa Harvey-McPherson of Eastern Maine Healthcare Systems. Ms. Moody was absent for the first portion of the discussions and voting but re-joined the Commission for later deliberations and voting. It was also determined during these discussions that the Commission would request both an extension of the December 2 reporting deadline (to December 15) and an additional meeting so that the recommendations could be further discussed and finally voted on at the fourth meeting on December 2 and then the final report could be reviewed at a fifth meeting (see also future meetings planning below).

The Commission discussed, deliberated and conducted non-binding straw votes as follows:

Problem/issue	Identified/proposed solution	Voting information
Patients awaiting discharge remain hospitalized due to lack of appropriate/available placement.	Pay PPS hospitals a daily “days awaiting placement” for MaineCare eligible patients only. Rate will be identical to that paid to critical access hospitals under MaineCare manual. Implement total cap amount for reimbursement for fiscal year (\$1M/\$500K TBD). DHHS to address guardianship and APS processes contributing to unnecessary extended hospital stays. Develop “temporary guardianship process.”	10-1 in favor of implementing immediate legislative solution. 11-0 in favor of DHHS addressing with relevant parties, including hospitals and the judiciary.
Insufficient trained staff to serve complex patients (as well as general staffing problems for all patient populations).	Address costs of education and barriers to entry into field (work with DOL). Further examine possibility of certain facilities implementing in-house staff certification programs, such as CNA certification (work with DOE).	10-1 in favor of further study of proposal in a stakeholder group format.

<p>Insufficient resources to assist in placement of patients with complex medical conditions.</p>	<p>Add 2 FTE staff to Long-term Care Ombudsman program to assist in placement. Some statutory changes necessary to expand Ombudsman program authority.</p> <p>Add 1 FTE nurse education consultant to DHHS.</p> <p>DHHS to fund long-term care contracts for behavioral health support at facilities for care plan consults, treatment, staff education (specifics TBD).</p>	<p>11-0 in favor of immediate legislative solution.</p> <p>7-3 in favor of immediate legislative solution.</p> <p>11-0 in favor of immediate legislative solution.</p>
<p>Insufficient capacity across facility spectrum (NFs, SNFs, PNMI, etc.) to meet in-State demand.</p>	<p>Expand/reconfigure appendix C PNMI facilities.</p> <p>Expand or improve community placement options. Members will bring back specific recommendations. One proposal might include implementing an enhanced reimbursement rate for home care services.</p>	<p>12-0 in favor of further study of proposal in a stakeholder group format.</p> <p>10-2 in favor of immediate legislative solution.</p>
<p>Insufficient contract compliance and enforcement by DHHS against facilities violating patient rights.</p>	<p>Change to 22 MRSA §7948 regarding unlawful discharges. Additional statutory or regulatory changes to clarify DHHS licensing authority with respect to unlawful discharges (specifics TBD).</p>	<p>12-0 in favor of further study of proposal in a stakeholder group format.</p>
<p>60 mile rule, which allows patient to refuse placement at facility greater than 60 miles from residence, may prevent appropriate placement of complex patients.</p>	<p>Exception to 60 mile rule for patients who have been waiting more than 30 days for placement.</p>	<p>10-3 against changing the 60 mile rule (i.e., do not include as recommendation).</p>
<p>MaineCare application approval process takes too long (45 days average processing time).</p>	<p>Implement presumptive eligibility option for facilities to presume patient's MaineCare eligibility.</p>	<p>10-1 in favor of further study of proposal in a stakeholder group format.</p>

	<p>Work with DHHS to specifically expedite application process for hospitalized patients awaiting placement.</p> <p>Amend MaineCare application process to better account for financial exploitation situations.</p>	<p>10-1 in favor of further study of proposal in a stakeholder group format.</p> <p>12-0 in favor of further study of proposal in a stakeholder group format.</p>
<p>Insufficient data is collected regarding basis for facility refusal of placement.</p>	<p>Establish method for data collection to increase understanding of these problems, such as requiring facilities to file simple report with DHHS identifying barriers to admission when refusing to admit patient (specifics TBD).</p>	<p>10-2 in favor of immediate legislative solution.</p>
<p>Family member or other theft of patient assets complicates MaineCare eligibility and delays provision of necessary services.</p>	<p>Increase efforts for prosecution of these types of cases (specifics TBD; DHHS will provide suggestions).</p>	<p>12-0 in favor of immediate legislative solution.</p>
<p>Currently insufficient geropsych capacity in Maine (usually most beds full).</p>	<p>Provide statutory authority to waive CON to facilitate the expansion of geropsych beds in State (NF and/or PNMI expansion) and implement all other necessary statutory or regulatory changes to accomplish this.</p>	<p>11-1 in favor of immediate legislative solution.</p> <p>Note DHHS testimony that RFI will go out in December to solicit responses for medical and psychiatric needs patients, special medical needs patients and neurobehavioral needs patients.</p>
<p>Despite immediate needs, geropsych placement process for open bed takes too long (often 6 weeks).</p>	<p>Implement options for improving/speeding up placement process, including addressing application of criterion that patient has “long history of mental illness” and challenges in applying PASRR process to geropsych patients.</p>	<p>11-0 in favor of further study of proposal in a stakeholder group format.</p>

Insufficient capacity/ placement options (“step- down”) for geropsych patients who no longer require that level or type of care.	Increase facility options to address geropsych patients developing dementia, including residential care options at geropsych facilities and addressing problems with assessment criteria for both admission and discharge (PASRR v. GOOLD).	11-0 in favor of further study of proposal in a stakeholder group format.
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Future meetings

The fourth meeting of the Commission will be held on Wednesday, December 2, at 10:00 am. The Commission will request approval for an additional, fifth meeting, to be held on Monday, December 7, time to be determined. Both meetings will be held in Room 216 of the Cross State Office Building.

The meeting was adjourned at 4:10 p.m.

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